Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025

A This return/report is for:
- [X] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- [ ] a single-employer plan
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report
- [ ] the final return/report
- [ ] an amended return/report
- [ ] a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [X]

D Check box if filing under:
- [X] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ▶ [ ]

Part II Basic Plan Information—enter all requested information

1a Name of plan
CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 06/01/1980

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
BOARD OF TRUSTEES, CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE

PO BOX 34203
SEATTLE, WA 98124

2b Employer Identification Number (EIN) 91-1106482

2c Plan Sponsor's telephone number 206-441-7574

2d Business code (see instructions) 238100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	01/13/2026	ERIC COFFELT
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	01/12/2026	FRANK GARRETT CONDEL IV
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:

a Sponsor's name

c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	1478
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	1317
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	1183
b	Retired or separated participants receiving benefits	**6b**	154
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	1337
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	179

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4B 4D 4E 4F 4Q

9a Plan funding arrangement (check all that apply)

- **(1)** [ ] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- **(4)** [ ] **DCG** (Individual Plan Information) – Number Attached _____
- **(5)** [ ] **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- **(1)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached 4
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [X] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☒ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025

A Name of plan
CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE

D Employer Identification Number (EIN)
91-1106482

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
WILLAMETTE DENTAL OF WASHINGTON, INC.

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
91-1702099	47050	WA34	582	04/01/2024	03/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	6d	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			7b	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [X] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	295165		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	295165
b Benefit charges (1) Claims paid	**9b(1)**	222192		
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	222192
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**	29517		
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**	5165		
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	34682
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	0
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025

A Name of plan
CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE

D Employer Identification Number (EIN)
91-1106482

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
THE UNION LABOR LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1423090	69744	SL10358	1336	04/01/2024	03/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
98174	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

DIMARTINO ASSOCIATES
1325 4TH AVE, STE 1705
SEATTLE, WA 98101

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
61359	0	N/A	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

GAIL E MCGINN INSURANCE INC
7021 NE 138TH PL
KIRKLAND, WA 98034

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
36815	0	N/A	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	6d	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			7b	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [X] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	0
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	0
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	1227589
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025

A Name of plan
CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE

D Employer Identification Number (EIN)
91-1106482

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
USABLE LIFE

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
71-0505232	94358	50054633	1342	04/01/2024	03/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
39560	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

GAIL E MCGINN INSURANCE INC
7021 NE 138TH PL
KIRKLAND, WA 98034

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
19780	0	N/A	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

BROWN & BROWN OF WASHINGTON INC
2106 PACIFIC AVE STE 501
TACOMA, WA 98402

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
13737	0	N/A	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

BROWN & BROWN INSURANCE SERVICES IN
10151 SEERWOOD PARK BLVD B100
JACKSONVILLE, FL 32256

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
6043	0	N/A	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	6d	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			7b	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [X] Other (specify) ▶ AD&D

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	0
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	0
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	0
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	312376
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025

A Name of plan
CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE

D Employer Identification Number (EIN)
91-1106482

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
UNITED HEALTHCARE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
36-2739571	79413	S5820	111	01/01/2024	12/31/2024

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	6d	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			7b	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [X] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	0
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	0
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	0
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	125283
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2024** **This Form is Open to Public Inspection.**

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025

A Name of plan
CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE

D Employer Identification Number (EIN)
91-1106482

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. . . . . [X] Yes [ ] No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

DODGE & COX

94-1441976

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

METROPOLITAN WEST

95-4597302

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

THE VANGUARD GROUP, INC

23-1945930

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

WELFARE & PENSION ADMIN SVC, INC.

91-1363171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 12 13 14 15 50 99	NONE	994357	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [X]

(a) Enter name and EIN or address (see instructions)

VERA WHOLE HEALTH INC

PO BOX 103148
PASADENA, CA 91189

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	978910	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

(a) Enter name and EIN or address (see instructions)

ZELIS CLAIMS INTEGRITY

2 CROSSROADS DR
BEDMINSTER, NJ 07921

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	744609	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

AETNA LIFE INSURANCE COMPANY

06-6033492

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	392348	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

BARLOW & COUGHRAN, P.S.

91-0889948

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	71976	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

ALAFFIA HEALTH

169 MADISON AVE #2049
NEW YORK, NY 10016

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	44457	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

WASHINGTON CAPITAL MANAGEMENT, INC.

91-1042342

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 50 51	NONE	37430	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

CHANGE HEALTHCARE SOLUTIONS, LLC

20-5716594

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	28911	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

CLIFTONLARSONALLEN LLP

41-0746749

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	25397	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

TRANSCARENT, INC.

84-3296541

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	24873	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

(a) Enter name and EIN or address (see instructions)

GAIL E MCGINN INSURANCE INC

91-1652776

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 22 50	NONE	21000	Yes [X] No [ ]	Yes [X] No [ ]	2278	Yes [ ] No [X]

(a) Enter name and EIN or address (see instructions)

RAEL & LETSON

94-1701048

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11 50	NONE	20000	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

DIMARTINO ASSOCIATES

91-0378940

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 22 50	NONE	19250	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [X]

(a) Enter name and EIN or address (see instructions)

HEALTH CARE COST MGMT CORP OF AK

94-3283661

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	15908	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

(a) Enter name and EIN or address (see instructions)

US BANK

31-0841368

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 50 62	NONE	10476	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [X]

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

HIGHLAND CAPITAL ADVISORS

20-4284376

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 50	NONE	7572	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

(a) Enter name and EIN or address (see instructions)

BANK OF AMERICA

94-1687665

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
18 50 62	NONE	7544	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [ ]

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
WELFARE & PENSION ADMIN SVC, INC.	99	0
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
ZELIS HEALTHCARE LLC 74-4319823	CLAIMS EDITING AND COST MANAGEMENT	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

SCHEDULE D (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration	**DFE/Participating Plan Information** This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	OMB No. 1210-0110 **2024** **This Form is Open to Public Inspection.**

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025

A Name of plan CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN	**B** Three-digit plan number (PN) ▶ 501
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE	**D** Employer Identification Number (EIN) 91-1106482

Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)
(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: REAL ASSET INCOME FUND, LLC

b Name of sponsor of entity listed in (a): WASHINGTON CAPITAL MANAGEMENT, INC.

c EIN-PN 86-3454983-001	**d** Entity code E	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 3202913

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

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a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025

A Name of plan
CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE

D Employer Identification Number (EIN)
91-1106482

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	4585352	5704154
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	1623125	1602374
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	1707615	307478
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	1654322	1553327
(2) U.S. Government securities	1c(2)	3706579	4131526
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	2333790	2485924
(B) All other	1c(3)(B)	2106892	2164631
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)	3048629	3202913
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	18186388	19253893
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	38952692	40406220
Liabilities			
g Benefit claims payable	1g	2898859	4156295
h Operating payables	1h	197115	593653
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through1j)	1k	3095974	4749948
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	35856718	35656272

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	20758627	
(B) Participants	2a(1)(B)	1292431	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		22051058
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	75044	
(B) U.S. Government securities	2b(1)(B)	22984	
(C) Corporate debt instruments	2b(1)(C)	146885	
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		244913
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	686071	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		686071
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	6286496	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	6183069	
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		103427
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	186697	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		186697

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		154284
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		381436
c Other income	2c		539135
d Total income. Add all **income** amounts in column (b) and enter total	2d		24347021
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	19068084	
(2) To insurance carriers for the provision of benefits	2e(2)	1981628	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		21049712
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	3103801	
(3) Recordkeeping fees	2i(3)	46046	
(4) IQPA audit fees	2i(4)	26427	
(5) Investment advisory and investment management fees	2i(5)	45002	
(6) Bank or trust company trustee/custodial fees	2i(6)	18020	
(7) Actuarial fees	2i(7)	20000	
(8) Legal fees	2i(8)	71976	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	2079	
(11) Other expenses	2i(11)	164404	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		3497755
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		24547467
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		-200446
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) [X] Unmodified **(2)** [ ] Qualified **(3)** [ ] Disclaimer **(4)** [ ] Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) [ ] DOL Regulation 2520.103-8 **(2)** [ ] DOL Regulation 2520.103-12(d) **(3)** [X] neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: CLIFTONLARSONALLEN LLP **(2)** EIN: 41-0746749

d The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1) [ ] This form is filed for a CCT, PSA, DCG or MTIA. **(2)** [ ] It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e Was this plan covered by a fidelity bond?	4e	X		500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	4j	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? [ ] Yes [X] No

If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	**5b(2)** EIN(s)	**5b(3)** PN(s)

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) ..... ☐ Yes ☐ No ☐ Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN

FINANCIAL STATEMENTS, ERISA-REQUIRED SUPPLEMENTAL SCHEDULES, AND SUPPLEMENTAL INFORMATION

YEARS ENDED MARCH 31, 2025 AND 2024

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CliftonLarsonAllen LLP
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INDEPENDENT AUDITORS' REPORT

Board of Trustees
Cement Masons and Plasterers Health and Welfare Plan
Seattle, Washington

Report on the Audit of the Financial Statements

Opinion

We have audited the accompanying financial statements of Cement Masons and Plasterers Health and Welfare Plan (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of benefit obligations as of March 31, 2025 and 2024, and the related statements of changes in net assets available for benefits and changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of Cement Masons and Plasterers Health and Welfare Plan as of March 31, 2025 and 2024, and the changes in its net assets available for benefits and changes in benefit obligations for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Cement Masons and Plasterers Health and Welfare Plan and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Cement Masons and Plasterers Health and Welfare Plan's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Management is also responsible for maintaining a current Plan instrument, including all Plan amendments, administering the Plan, and determining that the Plan's transactions that are presented and disclosed in the financial statements are in conformity with the Plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Cement Masons and Plasterers Health and Welfare Plan's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Cement Masons and Plasterers Health and Welfare Plan's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Supplemental Schedules Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of assets (held at end of year) and reportable transactions as of and for the year ended March 31, 2025 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion, the information in the accompanying supplemental schedules are fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content is presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The schedules of administrative expenses for the years ended March 31, 2025 and 2024, are presented for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Lake Oswego, Oregon
January 7, 2026

CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
MARCH 30, 2025 AND 2024

	2025	2024
ASSETS		
INVESTMENTS (at Fair Value)		
Short-Term Funds	$ 1,553,327	$ 1,654,322
U.S. Government Securities	4,131,526	3,706,579
Corporate Bonds	4,567,697	4,310,753
Foreign Bonds	82,858	129,929
Mutual Funds	19,253,893	18,186,388
103-12 Investment Entity	3,202,913	3,048,629
Total Investments (at Fair Value)	32,792,214	31,036,600
RECEIVABLES		
Employer Contributions	1,602,374	1,623,125
Stop-Loss Refunds	-	1,433,721
Interest	33,404	34,773
Formulary Rebate	266,764	231,294
Total Receivables	1,902,542	3,322,913
CASH	5,704,154	4,585,352
PREPAID EXPENSES	7,310	7,827
Total Assets	40,406,220	38,952,692
LIABILITIES AND NET ASSETS AVAILABLE FOR BENEFITS		
LIABILITIES		
Accounts Payable	593,653	197,115
Total Liabilities	593,653	197,115
NET ASSETS AVAILABLE FOR BENEFITS	$ 39,812,567	$ 38,755,577

See accompanying Notes to Financial Statements.

CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
YEARS ENDED MARCH 30, 2025 AND 2024

	2025	2024
ADDITIONS:		
CONTRIBUTIONS		
Employer	$ 20,653,759	$ 19,376,209
Employee	167,680	126,912
Retiree	1,124,751	1,273,220
Reciprocal	104,868	212,103
Total Contributions	22,051,058	20,988,444
INVESTMENT INCOME		
Net Appreciation in Fair Value of Investments	825,844	1,111,168
Interest and Dividends	930,984	860,102
Total Investment Income	1,756,828	1,971,270
Less: Investment Expenses	(63,022)	(63,223)
Net Investment Income	1,693,806	1,908,047
OTHER INCOME		
Formulary Rebates	519,608	407,184
Other Income	19,527	38,081
Total Other Income	539,135	445,265
Total Additions	24,283,999	23,341,756
DEDUCTIONS:		
COST OF BENEFITS PAID		
Benefits	14,457,718	15,210,818
Transfers to Credit Union	3,352,930	-
Premiums	1,981,628	2,045,320
Total Cost of Benefits Paid	19,792,276	17,256,138
ADMINISTRATIVE EXPENSES	3,434,733	2,293,070
Total Deductions	23,227,009	19,549,208
NET INCOME	1,056,990	3,792,548
NET ASSETS AVAILABLE FOR BENEFITS:		
Beginning of Year	38,755,577	34,963,029
End of Year	$ 39,812,567	$ 38,755,577

See accompanying Notes to Financial Statements.

CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN
STATEMENTS OF BENEFIT OBLIGATIONS
MARCH 30, 2025 AND 2024

	2025	2024
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS		
Claims Payable	$ 169,095	$ 414,859
Claims Incurred but Not Reported	3,987,200	2,484,000
Total Amounts Currently Payable to or for Participants	4,156,295	2,898,859
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE AT ESTIMATED AMOUNTS		
Accumulated Eligibility Credits	8,469,500	9,666,700
Total Other Obligations for Current Benefit Coverage at Estimated Amounts	8,469,500	9,666,700
TOTAL OBLIGATIONS OTHER THAN POSTRETIREMENT BENEFIT OBLIGATIONS	12,625,795	12,565,559
POSTRETIREMENT BENEFIT OBLIGATIONS		
Current Retirees	15,045,200	16,251,500
Other Participants Fully Eligible for Benefits	7,391,700	9,494,700
Other Participants Not Fully Eligible for Benefits	16,054,200	21,469,600
Total Postretirement Benefit Obligations	38,491,100	47,215,800
TOTAL BENEFIT OBLIGATIONS	$ 51,116,895	$ 59,781,359

See accompanying Notes to Financial Statements.

CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN
STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS
YEARS ENDED MARCH 30, 2025 AND 2024

	2025	2024
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS		
Balance at Beginning of Year	$ 2,898,859	$ 3,196,072
Change in Claims Payable	(245,764)	266,787
Change in Claims Incurred but Not Reported	1,503,200	(564,000)
Balance at End of Year	4,156,295	2,898,859
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE AT ESTIMATED AMOUNTS		
Balance at Beginning of Year	9,666,700	10,179,218
Change in Accumulated Eligibility Credits	(1,197,200)	(512,518)
Balance at End of Year	8,469,500	9,666,700
TOTAL OBLIGATIONS OTHER THAN POSTRETIREMENT BENEFIT OBLIGATIONS	12,625,795	12,565,559
POSTRETIREMENT BENEFIT OBLIGATIONS		
Balance at Beginning of Year	47,215,800	52,669,700
Increase (Decrease) During the Year Attributed to:		
Service Cost	3,077,200	2,993,800
Interest Cost	2,488,800	2,617,300
Expected Benefit Payments	(1,045,200)	(1,135,700)
Actuarial Experience Gain	(3,894,500)	(5,197,500)
Census Demographic Changes	-	(2,291,900)
Change in Assumptions/Methods	(4,069,700)	(2,439,900)
Plan Amendments	(5,281,300)	-
Balance at End of Year	38,491,100	47,215,800
TOTAL BENEFIT OBLIGATIONS	$ 51,116,895	$ 59,781,359

See accompanying Notes to Financial Statements.

NOTE 1 DESCRIPTION OF THE PLAN

Cement Masons and Plasterers Health and Welfare Plan (the Plan) became effective June 1, 1980, as a result of an agreement between the Cement Masons Contractors Committee and Local 528, affiliated with the Operative Plasterers and Cement Masons International Association of the United States and Canada. The following description of the Plan is provided for general information purposes only. Participants should refer to the Plan document for more complete information.

General

The Plan provides health and other benefits for eligible employees of participating employers under the collective bargaining agreement. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Contributions and Benefits

Participating employers contribute to the Plan a stipulated amount for each hour worked by the member pursuant to the current collective bargaining agreement. Each participant reported to the Plan is assigned a dollar bank reserve account into which employer contributions are deposited as they are received from participating employers. In order to be initially eligible under the Plan, a participant must accumulate contributions sufficient in his or her dollar bank reserve account to purchase two months of coverage, the cost of which is determined from time to time by the Board of Trustees. Coverage will commence on the first day of the second month thereafter.

If, after becoming initially insured, a participant maintains the required contributions in his or her account, each month the participant will have the cost of one month's coverage deducted from his or her account, for coverage on the first day of the second month following.

If a participant's account balance is reduced below the cost of one full month's coverage, the participant may make a self-payment to the trust to make up the shortage in the dollar bank reserve account. If the participant does not elect to make a self-payment to make up the bank reserve shortage, any unused balances accumulated in the participant account will be maintained to apply toward future coverage once the participant again accumulates the required contributions in his or her account.

Self-paid coverage is available to a retired employee who is at least 63 years of age, has retired from active employment for a covered employer, no longer qualifies for insurance under the group policy as an active employee or associate employee, and meets certain other conditions.

The Plan provides life, accidental death and dismemberment (AD&D), weekly disability income, medical, dental, vision, and prescription benefits for all eligible employees and covered dependents.

NOTE 1 DESCRIPTION OF THE PLAN (CONTINUED)

Contributions and Benefits (Continued)

Effective June 1, 2024, the Plan provides a Paid Time Off (PTO) Plan to eligible participants. Participants in the PTO Plan have their contributions transferred from the Plan to QualStar Credit Union (the Credit Union). Individual accounts are established in the participants' names, at the Credit Union, upon the participants' establishment of the account following their initial transfer. Benefits are paid by transferring the funds to individual participant's accounts, which are maintained at the Credit Union. Transfers for benefits totaled $3,352,930 and $-0- during the years ended March 31, 2025 and 2024, respectively.

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

The Plan's financial statements are prepared using the accrual basis of accounting.

Contributions

Contributions from employers are accrued based upon reported hours worked during the year by covered employees.

Postretirement Benefit Obligation

The postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed to employee service rendered to March 31, 2025 and 2024, reduced by the actuarial present value of contributions expected to be received in the future from current Plan participants. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired or terminated employees and their beneficiaries and dependents, and (2) active employees and their beneficiaries and dependents after retirement from service with the participating employers. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service in the industry rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation is determined by an actuary and is the amount that results from applying actuarial assumptions to historical claims-cost data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal, or retirement) between the valuation date and the expected date of payment.

From the current levels, the net health costs, operating expenses, and self-pay contributions will increase each year in the future. For net health costs, the initial trend rates reflect cost increases that are expected over the next few years. The initial trend rates of 5.25% at March 31, 2025, and 5.50% at March 31, 2024, gradually taper to the expected long-term trend of 4.0% by 2030.

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Postretirement Benefit Obligation (Continued)

The following were other significant assumptions used in the valuations as of March 31, 2025 and 2024.

Weighted-Average Discount Rate: 5.50% for 2025; 5.00% for 2024

Retirement Rates:

Age	< 30 Years	30 Years	31+ Years
55 - 61	8.0 %	50.0 %	40.0 %
62	25.0	50.0	40.0
63 - 64	35.0	50.0	40.0
65+	100.0	100.0	100.0

Mortality: Pri-2012 Blue Collar Dataset Headcount-Weighted Mortality set forward two years and projected five years using SOA Scale MP-2020

The foregoing assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of the postretirement benefit obligations.

During 2025, the postretirement benefit obligations liability in total decreased approximately $8.72 million. $5.28 million of this decrease was due to an amendment in the Plan which will only offer one Rx coverage option and all Medicare Retirees (aside from those who waived Rx coverage) moving into the same individual Part D prescription drug plan with the Plan's self-funded plan providing wrap-around coverage. $4.07 million of this decrease was due to the Plan increasing its discount rate from 5.00% to 5.50%. The remaining $0.63 million increase related to changes in benefits earned and other changes.

During 2024, the postretirement benefit obligations liability in total decreased approximately $5.45 million. Benefits earned and other changes amounted to a $3.01 million decrease. This was composed of a $4.48 million increase due to expected interest, service cost and benefits paid and a $7.49 million decrease for demographic/financial plan experience that was different than previously assumed. The remaining $2.44 million decrease was related to changes in actuarial assumptions.

The deficit of benefit obligations over net assets available for benefits at March 31, 2025 and 2024 relates primarily to the postretirement benefit obligation, the funding of which is not covered by the contribution rate provided by the current bargaining agreement.

The weighted-average health care cost-trend rate assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates increased by one percentage point in each year, it would increase the obligations as of March 31, 2025 and 2024 by $11,173,900 and $13,876,300, respectively.

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Postretirement Benefit Obligation (Continued)

The cost of the postretirement benefit obligations are shared by the Plan's participating employers and retirees. In addition to deductibles and co-payments, retiree contributions are expected to fund 55% of the estimated cost of retirement benefits as of March 31, 2025 and 2024.

Benefits

Benefits are recorded when paid by the Plan.

Investment Valuation

The Plan's investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Plan's Board of Trustees determines the Plan's valuation policies utilizing information provided by the investment advisers, and custodian. See Note 6 for discussion of fair value measurements.

Purchases and sales of securities are reflected on a trade-date basis. Interest income is recorded as earned on an accrual basis. Dividend income is recorded on the ex-dividend date. Net appreciation (depreciation) includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires Plan management to make estimates and assumptions that affect the reported amount of assets and liabilities, benefit obligations and changes therein, and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could vary from the estimates that were used.

Employer Contributions Receivable

Contributions due but not paid prior to year-end are recorded as contributions receivable. Contributions are due from employers as specified in the collective bargaining or participation agreement. In general, contributions are due on the 15th day of each month following the work month. Delinquent contributions and payroll audit findings are individually analyzed for collectability. The estimate for expected credit losses considers historical loss experience, current economic conditions, and forward-looking information, including factors such as payment history, employer financial condition, and labor trends. As of March 31, 2025 and 2024, the allowance for credit losses was insignificant.

Reciprocal Contributions

The Plan has entered into various reciprocal agreements with other union health plans. In accordance with these agreements, the Plan is required to remit funds received, and is entitled to receive funds, from participating employers on behalf of temporary employees to and from the employees' participating local union(s).

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Subsequent Events

In preparing these financial statements, the Plan has evaluated events and transactions for potential recognition or disclosure through January 7, 2026, the date the financial statements were available to be issued.

NOTE 3 PLAN TERMINATION

The trust agreement shall cease and terminate upon the happening of any one or more of the following events:

a. In the event the Plan shall, in the opinion of the trustees, be inadequate to carry out the intent and purpose of the trust agreement, or be inadequate to meet the payments due or to become due under the trust agreement and under the Plan of benefits to participants and beneficiaries already drawing benefits;

b. In the event there are no individuals living who can qualify as employees hereunder;

c. In the event of termination by action of the union and the committee, and

d. In the event of termination as may be otherwise provided by law.

In the event of termination, the trustees shall:

a. Make provision out of the Plan for the payment of expenses incurred up to the date of termination of the trust and the expenses incidental to such termination;

b. Arrange for a final audit and report of their transactions and accounts, for the purpose of termination of their trusteeship;

c. Apply the Plan to pay any and all obligations of the trust and distribute and apply any remaining surplus in such manner as will, in their opinion, best effectuate the purposes of the trust and the requirements of law, and

d. Give any notices and prepare and file any reports which may be required by law.

NOTE 4 SELF-FUNDING OF PLAN

The Board of Trustees elected to self-fund the Plan effective May 1, 1995. The life, AD&D, and dependent life coverage is insured through USAble Life. Stop-loss coverage is insured through The Union Labor Life Insurance Company, for the years ended March 31, 2025 and 2024, and dental coverage is insured through Willamette Dental.

Benefits paid are reported net of stop-loss reimbursements of $-0- and $-1,726,674 for the years ended March 31, 2025 and 2024, respectively. There were stop-loss refunds receivable of $-0- and $1,433,721 at March 31, 2025 and 2024, respectively.

NOTE 4 SELF-FUNDING OF PLAN (CONTINUED)

Claims payable represents amounts for claims incurred and reported during the Plan year and paid for subsequently. The claims payable is estimated at $169,095 and $414,859 as of March 31, 2025 and 2024, respectively. The reserve for claims incurred but not reported (IBNR) represents claims incurred at year-end but not paid. The IBNR reserve is estimated at $3,987,200 and $2,484,000 at March 31, 2025 and 2024, respectively.

NOTE 5 LIABILITY FOR FUTURE BENEFITS

The Plan is required to provide benefits to certain members, if such members have accumulated credit amounts (expressed in dollars) in excess of that required for current coverage. Current dollar bank values cannot exceed the $11,000 cap. Participants draw down their bank value whenever they fail to meet the 130-hour per month requirement. The estimated future liability at March 31, 2025 and 2024, a result of hours processed for the months of March 31, 2025 and 2024 and prior, amounted to $8,469,500 and $9,666,700, respectively.

NOTE 6 FAIR VALUE MEASUREMENTS

The framework for measuring fair value provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy are described as follows:

Level 1 – Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly, such as:

- quoted prices for similar assets or liabilities in active markets;
- quoted prices for identical or similar assets or liabilities in inactive markets;
- inputs other than quoted prices that are observable for the asset or liability;
- inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair market value measurement.

NOTE 6 FAIR VALUE MEASUREMENTS (CONTINUED)

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs. There have been no changes in the valuation methodologies used at March 31, 2025 and 2024.

Following is a description of the valuation methodologies used for assets measured at fair value.

Short-Term Funds – Valued at the net asset value (NAV), which is based on the value of the underlying securities.

Corporate and Foreign Bonds and U.S. Government Securities – Valued using pricing models maximizing the use of observable inputs for similar securities. This includes basing value on yields currently available on comparable securities of issuers with similar credit ratings, when applicable.

Mutual Funds – Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-end mutual funds that are registered with the SEC. These funds are required to publish their daily NAV and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

103-12 Investment Entity – Valued at NAV per unit (or its equivalent) based upon the fair value of the underlying investments. NAV is used as a practical expedient to estimate fair value.

The following tables set forth by level, within the fair value hierarchy, the Plan's investment assets at fair value as of March 31:

	2025			
	Level 1	Level 2	Level 3	Total
Short-Term Funds	$ 1,553,327	$ -	$ -	$ 1,553,327
Mutual Funds	19,253,893	-	-	19,253,893
U.S. Government Securities	-	4,131,526	-	4,131,526
Corporate Bonds	-	4,567,697	-	4,567,697
Foreign Bonds	-	82,858	-	82,858
Total Investments in the Fair Value Hierarchy	$ 20,807,220	$ 8,782,081	$ -	29,589,301
Investments Measured at NAV				3,202,913
Total Investments at Fair Value				$ 32,792,214

NOTE 6 FAIR VALUE MEASUREMENTS (CONTINUED)

	2024			
	Level 1	Level 2	Level 3	Total
Short-Term Funds	$ 1,654,322	$ -	$ -	$ 1,654,322
Mutual Funds	18,186,388	-	-	18,186,388
U.S. Government Securities	-	3,706,579	-	3,706,579
Corporate Bonds	-	4,310,753	-	4,310,753
Foreign Bonds	-	129,929	-	129,929
Total Investments in the Fair Value Hierarchy	$ 19,840,710	$ 8,147,261	$ -	27,987,971
Investments Measured at NAV				3,048,629
Total Investments at Fair Value				$ 31,036,600

The following tables and descriptions set forth additional disclosures for the fair value measurement of investments in certain entities that calculate NAV per share (or its equivalent) as of March 31:

	2025			
Investment Type	Fair Value	Unfunded Commitments	Redemption Frequency	Redemption Notice Period
103-12 Investment Entity:				
Real Asset Income Fund LLC	$ 3,202,913	$ -	Monthly	30 Days Prior to Redemption Date

	2024			
Investment Type	Fair Value	Unfunded Commitments	Redemption Frequency	Redemption Notice Period
103-12 Investment Entity:				
Real Asset Income Fund LLC	$ 3,048,629	$ -	Monthly	30 Days Prior to Redemption Date

NOTE 7 RISKS AND UNCERTAINTIES

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risk. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of the investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statements of net assets available for benefits.

The postretirement benefit obligation is reported based on certain assumptions pertaining to interest rates, health care trend rates, and employee demographics, all of which are subject to change. The estimate for claims incurred but not reported is based on certain assumptions pertaining to health care trend rates, claims lag, and historical claims data. The estimate for accumulated eligibility credits is based on certain assumptions pertaining to health care trends and inflation rates. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

NOTE 8 TAX STATUS

The Trust established under the Plan to hold the Plan's assets is qualified pursuant to the appropriate section of the Internal Revenue Code (IRC) and, accordingly, the trust's net investment income is exempt from income taxes. The Plan obtained its latest determination letter on June 11, 1981, in which the Internal Revenue Service (IRS) stated that the Plan, as designed, was in compliance with the applicable requirements of the IRC. The Plan has been amended since receiving the determination letter. However, the Plan administrator believes that the Plan is designed and is currently being operated in compliance with the applicable requirements of the IRC.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

NOTE 9 RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits at March 31 per the financial statements to Form 5500:

	2025	2024
Net Assets Available for Benefits per the Financial Statements	$ 39,812,567	$ 38,755,577
Less: Claims Payable	(169,095)	(414,859)
Less: Claims Incurred But Not Reported	(3,987,200)	(2,484,000)
Net Assets Available for Benefits per Form 5500	$ 35,656,272	$ 35,856,718

The following is a reconciliation of cost of benefits paid per the financial statements to Form 5500 for the year ended March 31, 2025:

Cost of Benefits Paid per the Financial Statements	$ 19,792,276
Add: Change in Claims IBNR	1,503,200
Add: Change in Claims Payable	(245,764)
Benefit Payments and Payments to Provide Benefits per Form 5500	$ 21,049,712

NOTE 10 PARTY-IN-INTEREST TRANSACTIONS

The Plan pays expenses related to Plan operations and investment activity to various service providers. These transactions are exempt party-in-interest transactions under ERISA.

CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN
E.I.N. 91-1106482 PLAN NO. 501
SCHEDULE H, LINE 4i—SCHEDULE OF ASSETS (HELD AT END OF YEAR)
MARCH 30, 2025

(a)	(b)	(c)			(d)	(e)
	Identity of Issue, Borrower, Lessor, or Similar Party	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value			Cost	Current Value
		Maturity Date	Rate of Interest	Shares		
	SHORT-TERM FUNDS					
	First American Govt Oblig Fund		Variable	1,553,327	$ 1,553,327	$ 1,553,327
	Total Short-Term Funds				1,553,327	1,553,327
	U.S. GOVERNMENT SECURITIES					
	Federal Home Loan Mortgage Corporation	12/25/26	3.360	20,000	18,900	19,691
	Federal Home Loan Mortgage Corporation	7/15/27	1.500	12,302	11,744	12,022
	FNMA Guaranteed REMIC	5/25/33	1.850	128,369	115,051	119,187
	FNMA Guaranteed REMIC	3/25/33	4.000	10,618	10,406	10,479
	FNMA Guaranteed REMIC	11/25/39	6.000	3,038	3,038	3,040
	FNMA Guaranteed REMIC	4/25/40	4.000	76,985	75,831	76,362
	FNMA Guaranteed REMIC	2/16/37	1.705	15,337	15,178	15,210
	FNMA Guaranteed REMIC	7/16/41	2.500	67,716	64,721	66,220
	US Treasury Note	3/31/26	0.750	70,000	65,621	67,759
	US Treasury Note	8/31/26	0.750	532,000	501,503	508,640
	US Treasury Note	4/30/27	0.500	1,600,000	1,468,872	1,492,128
	US Treasury Note	7/31/26	0.625	350,000	330,121	334,880
	US Treasury Note	11/30/27	0.625	180,000	162,984	165,249
	US Treasury Note	9/30/25	0.250	1,050,000	1,028,811	1,029,662
	US Treasury Note	10/31/27	0.500	230,000	201,310	210,997
	Total U.S. Government Securities				4,074,091	4,131,526
	CORPORATE DEBT SECURITIES					
	ALTRIA GROUP INC SR	5/6/25	2.350	120,000	123,354	119,701
	AMERICAN EXPRESS	8/16/27	3.750	90,000	87,156	89,713
	AMERICREDIT AUTO	10/19/26	0.890	28,072	27,737	27,945
	AMERICREDIT	1/19/27	1.010	61,088	59,422	60,215
	APACHE CORP	10/15/28	4.375	100,000	94,280	96,091
	AUTOZONE INC	4/15/25	3.625	100,000	112,815	99,947
	BANK OF AMERICA	5/15/28	4.790	50,000	49,414	50,226
	BANK OF AMERICA	11/15/27	3.530	100,000	97,156	99,789
	BOEING CO	2/4/26	2.196	55,000	53,007	53,812
	CAPITAL ONE MULTI	8/15/28	2.060	100,000	96,531	96,988
	CAPITAL ONE MULTI	10/15/27	4.950	100,000	39,538	40,080
	CAPITAL ONE PRIME TR	4/15/27	1.400	100,000	97,309	98,713
	CAPITAL ONE PRIME TR	9/15/26	0.770	4,805	4,573	4,778
	CARMAX AUTO OWN	10/15/27	5.480	26,104	26,119	26,169
	CARMAX AUTO OWN	11/16/26	5.720	14,789	14,786	14,806
	CATERPILLAR FINL MTN	11/13/25	0.800	100,000	97,761	97,936
	CENTENE CORP DEL SR	12/15/27	4.250	45,000	42,572	43,910
	CHASE ISSUANCE	9/15/27	3.970	120,000	116,650	119,674
	CHASE ISSUANCE	1/15/31	4.630	90,000	89,917	90,862
	CITIBANK	12/8/27	5.230	42,000	41,979	42,189
	CONOCOPHILLIPS CO	5/15/25	3.350	52,000	50,141	51,908
	CVS HEALTH CORP	7/20/25	3.875 %	155,000	170,664	154,551
	DANA INC	6/15/28	5.625	50,000	48,621	49,261
	DISC CARD EXEC NT	9/15/28	1.030	30,000	27,142	28,614

CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN
E.I.N. 91-1106482 PLAN NO. 501
SCHEDULE H, LINE 4i—SCHEDULE OF ASSETS (HELD AT END OF YEAR) (CONTINUED)
MARCH 30, 2025

(a)	(b)	(c)			(d)	(e)
	Identity of Issue, Borrower, Lessor, or Similar Party	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value			Cost	Current Value
		Maturity Date	Rate of Interest	Shares		
CORPORATE DEBT SECURITIES (CONTINUED)						
	DISCOVER CARD EXE	7/15/27	3.560	80,000	$ 77,784	$ 79,742
	DPL INC	7/1/25	4.125	50,000	47,426	49,722
	DTE ELEC CO	12/1/26	4.850	25,000	24,996	25,251
	ENLINK MIDSTREAM	7/15/26	4.850	45,000	43,720	45,050
	FORD CR AUT OWN TR	4/15/29	5.100	31,000	30,917	31,388
	GM FINI CONS AT	12/17/29	4.980	100,000	99,993	100,610
	GM FIN CONS ATMB	10/16/26	0.000	62,179	59,646	61,916
	GM FIN CONS AUTO	08/16/27	4.820	28,724	28,571	28,737
	GM FIN CONS AUTO	4/17/28	1.510	40,000	36,352	39,161
	GOODYEAR TIRE RUBR	7/15/29	5.000	50,000	47,467	46,380
	HONDA AUTO REC	6/21/28	1.140	150,000	141,149	149,250
	HONDA AUTO REC OWN	12/18/28	3.760	40,000	39,536	39,769
	HONDA AUTO REC OWN	11/18/26	5.480	70,130	70,128	70,332
	HOWMET AEROSPACE INC	1/15/29	3.000	100,000	90,030	94,150
	HYUNDAI AUTO REC TR	2/16/27	0.600	9,171	8,584	9,099
	HYUNDAI AUTO REC TR	8/15/28	3.800	30,000	29,592	29,837
	HYUNDAI AUTO REC	10/15/26	2.220	19,141	19,009	19,057
	MERCEDES BENZ AUTO	8/16/27	5.210	38,213	38,108	38,324
	MERCEDES BENZ AUTO	11/15/27	4.510	81,932	81,871	81,911
	MERCEDES BENZ AUTO	4/16/29	4.310	100,000	99,441	99,956
	METHANEX CORP	10/15/27	5.125	40,000	38,240	39,218
	NISSAN AT REC	8/17/26	1.860	19,347	18,908	19,227
	NISSAN AUTO	9/15/27	0.570	109,957	105,166	108,709
	NUSTAR LOGISTICS LP	4/28/27	5.625	40,000	39,290	39,832
	PBF HLDG CO LLC	2/15/28	6.000	50,000	48,724	46,502
	PHILIP MORRIS INTL	2/25/26	2.750	100,000	95,485	98,466
	PINNACLE WEST CAP	6/15/25	1.300	80,000	78,390	79,390
	PUGET ENERGY INC	6/15/28	2.379	82,000	75,019	76,233
	SANT ER DRIVE	10/15/27	5.610	34,259	34,292	34,327
	SUBURBAN PROPANE	3/1/27	5.875	40,000	39,482	39,785
	TEGNA INC	3/15/28	4.625	50,000	45,832	47,300
	TEVA PHARMACEUTICALS	10/1/26	3.150	45,000	39,929	43,640
	TOYOTA AUTO REC	2/15/28	4.150	15,000	14,700	14,882
	TRI POINTE GROUP INC	6/1/27	5.250	40,000	38,642	39,483
	TRUIST FINL CORP MTN	8/5/25	1.200	100,000	102,052	98,833
	US AIRWAYS 2013	5/15/27	3.950	77,729	76,313	77,198
	VERIZON MASTER	11/20/28	3.400	120,000	117,288	119,797
	VERIZON MASTER TRUST	6/20/29	5.160	102,000	101,688	102,869
	VERIZON MASTER TRUST	9/8/28	5.970	50,000	49,808	50,237
	VERIZON MASTER TRUST	8/20/30	4.170	70,000	69,500	69,675
	VIRGINIA PWR FUEL	5/1/29	5.088	29,808	29,848	29,997
	VOLKSWAHEN AUTO LN	6/22/26	1.020	1,169	1,138	1,167
	VOLKSWAHEN AUTO LN	10/20/28	1.260	85,000	78,977	84,221
	WARNERMEDIA HLDGS	3/15/27	3.755	115,000	110,954	112,166
	WF CARD ISSUANCE	10/15/29	4.290	100,000	99,441	99,978
	WORLD OMNI AUTO	6/15/27	1.040	80,000	75,806	79,343
	WORLD OMNI AUTO	12/15/26	5.570	12,569	12,562	12,578
	WORLD OMNI AUTO	3/15/30	4.990	100,000	99,993	101,063
	WORLD OMNI AUTO	6/15/27	0.690	87,554	80,274	86,919
	Total Corporate Debt Securities				4,600,706	4,650,555

CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN
E.I.N. 91-1106482 PLAN NO. 501
SCHEDULE H, LINE 4i—SCHEDULE OF ASSETS (HELD AT END OF YEAR) (CONTINUED)
MARCH 30, 2025

(a)	(b)	(c)			(d)	(e)
	Identity of Issue, Borrower, Lessor, or Similar Party	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value			Cost	Current Value
		Maturity Date	Rate of Interest	Shares		
	REGISTERED INVESTMENT COMPANIES					
	Dodge Cox Income			578,996	$ 8,060,834	$ 7,295,346
	Metropolitan West Total Return			838,451	8,388,680	7,135,215
	Vanguard Tot Int ST Idx Adm			52,675	1,469,328	1,756,175
	Vanguard Total Stock Mkt Idx Adm			22,932	1,321,925	3,067,157
	Total Registered Investment Companies				19,240,767	19,253,893
	103-12 INVESTMENT ENTITY					
	Real Asset Income Fund LLC			289,626	2,896,000	3,202,913
	Total Investment Assets				$ 32,364,890	$ 32,792,214

CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN
E.I.N. 91-1106482 PLAN NO. 501
SCHEDULE H, LINE 4j—SCHEDULE OF REPORTABLE TRANSACTIONS
YEAR ENDED MARCH 30, 2025

(a) Identity of Party Involved	(b) Description of Assets (Include Interest Rate and Maturity in Case of a Loan)	(c) Purchase Price	(d) Selling Price	(g) Cost of Assets	(h) Current Value of Assets on Transaction Date	(i) Net Gain or (Loss)
Category (ii) Series of Transactions						
Morgan Stanley	Variable Rate	$ -	$ 3,091,138	$ 3,000,367	$ 3,091,138	$ 90,771
Category (iii) Series of Transactions						
First American Govt Oblig Fund	Variable Rate	4,521,933	-	4,521,933	4,521,933	-
First American Govt Oblig Fund	Variable Rate	-	4,197,839	4,197,839	4,197,839	-

There were no category (i) or (iv) transactions for the year ended March 31, 2025.
Columns (e) and (f) are omitted, as they are not applicable.

CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN
SCHEDULES OF ADMINISTRATIVE EXPENSES
YEARS ENDED MARCH 30, 2025 AND 2024

	2025	2024
Administration Fees - WPAS	$ 380,565	$ 335,637
Administration Fees - Emdeon	27,725	7,946
Shared Administration Fees - WPAS	66,000	66,000
Case Management Fees - First Choice	15,908	23,483
Claims Processing Fees	2,613,603	1,581,131
Collection Costs	46,811	15,487
Actuarial Fees	20,000	6,750
Legal Fees	25,165	20,053
Consultant Fees	40,250	42,000
Audit Fees	26,427	28,186
Payroll Audit Fees	46,046	53,421
Other Professional Fees	-	4,348
Insurance	18,400	17,061
Office and Printing	68,112	38,042
Postage	22,162	31,539
Trustee Meetings and Travel	8,995	12,500
Dues Registration	8,564	9,486
Total Administrative Expenses	$ 3,434,733	$ 2,293,070

CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN

EIN 91-1106482 PN 501 FYE 3/31/2025

Schedule H, line 4j - Schedule of Reportable Transactions - included in the Accountant's audit report attachment.

CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN

EIN 91-1106482 PN 501 FYE 3/31/2025

Schedule H, Line 4i - Schedule of Assets (Held at End of Year) - included in the Accountant's audit report attachment.